BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **JAMIE ELIZABETH COLE** **563 E. El Paso, #101** **Fresno, CA 93720** **Registered Nurse License No. 604968** Respondent	Case No. 2012-676 OAH No. 2012070279

DECISION AND ORDER

The attached Stipulated Surrender of License and Order is hereby adopted by the Board of Registered Nursing, Department of Consumer Affairs, as its Decision in this matter.

This Decision shall become effective on **December 12, 2012.**

IT IS SO ORDERED **December 12, 2012.**

Raymond Mallel, President
Board of Registered Nursing
Department of Consumer Affairs
State of California

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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **JAMIE ELIZABETH COLE** **563 E. El Paso, #101** **Fresno, CA 93720** **Registered Nurse License No. 604968** Respondent.	Case No. 2012-676 OAH No. 2012070279 **STIPULATED SURRENDER OF LICENSE AND ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties in this proceeding that the following matters are true:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) is the Executive Officer of the Board of Registered Nursing (Board). She brought this action solely in her official capacity and is represented in this matter by Kamala D. Harris, Attorney General of the State of California, by Antoinette B. Cincotta, Deputy Attorney General.

2. Jamie Elizabeth Cole (Respondent) is represented in this proceeding by attorney Susan Leigh Angell, whose address is Angell Law Office, 21769, Tahoe Lane, Lake Forest, CA 92630.

3. On or about August 21, 2002, the Board issued Registered Nurse License No. RN 604968 to Jamie Elizabeth Cole (Respondent). The Registered Nurse License was in full force

and effect at all times relevant to the charges brought in Accusation No. 2012-676, and will expire on October 31, 2013, unless renewed.

JURISDICTION

4. Accusation No. 2012-676 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on May 1, 2012. Respondent timely filed her Notice of Defense contesting the Accusation. A copy of Accusation No. 2012-676 is attached as Exhibit A and incorporated by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 2012-676. Respondent also has carefully read, fully discussed with counsel, and understands the effects of this Stipulated Surrender of License and Order.

6. Respondent is fully aware of her legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to confront and cross-examine the witnesses against her; the right to present evidence and to testify on her own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

7. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

8. Respondent admits the truth of each and every charge and allegation in Accusation No. 2012-676, agrees that cause exists for discipline and hereby surrenders her Registered Nurse License No. RN 604968 for the Board's formal acceptance.

9. Respondent understands that by signing this stipulation she enables the Board to issue an order accepting the surrender of her Registered Nurse License without further process.

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RESERVATION

10. The admissions made by Respondent herein are only for the purposes of this proceeding, or any other proceedings in which the Board of Registered Nursing or other professional licensing agency is involved, and shall not be admissible in any other criminal or civil proceeding.

CONTINGENCY

11. This stipulation shall be subject to approval by the Board. Respondent understands and agrees that counsel for Complainant and the staff of the Board may communicate directly with the Board regarding this stipulation and surrender, without notice to or participation by Respondent or her counsel. By signing the stipulation, Respondent understands and agrees that she may not withdraw her agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Surrender and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

12. The parties understand and agree that facsimile copies of this Stipulated Surrender of License and Order, including facsimile signatures thereto, shall have the same force and effect as the originals.

13. This Stipulated Surrender of License and Order is intended by the parties to be an integrated writing representing the complete, final, and exclusive embodiment of their agreement. It supersedes any and all prior or contemporaneous agreements, understandings, discussions, negotiations, and commitments (written or oral). This Stipulated Surrender of License and Order may not be altered, amended, modified, supplemented, or otherwise changed except by a writing executed by an authorized representative of each of the parties.

14. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Order:

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ORDER

IT IS HEREBY ORDERED that Registered Nurse License No. RN 604968 issued to Respondent Jamie Elizabeth Cole is surrendered and accepted by the Board.

1. The surrender of Respondent's Registered Nurse License and the acceptance of the surrendered license by the Board shall constitute the imposition of discipline against Respondent. This stipulation constitutes a record of the discipline and shall become a part of Respondent's license history with the Board of Registered Nursing.

2. Respondent shall lose all rights and privileges as a registered nurse in California as of the effective date of the Board's Decision and Order.

3. Respondent shall cause to be delivered to the Board her pocket license and, if one was issued, her wall certificate on or before the effective date of the Decision and Order.

4. If Respondent ever files an application for licensure or a petition for reinstatement in the State of California, the Board shall treat it as a petition for reinstatement. Respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked license in effect at the time the petition is filed, and all of the charges and allegations contained in Accusation No. 2012-676 shall be deemed to be true, correct and admitted by Respondent when the Board determines whether to grant or deny the petition.

5. If and when Respondent's license is reinstated, she shall pay to the Board costs associated with its investigation and enforcement pursuant to Business and Professions Code section 125.3 in the amount of $14,338.40. Respondent shall be permitted to pay these costs in a payment plan approved by the Board. Nothing in this provision shall be construed to prohibit the Board from reducing the amount of cost recovery upon reinstatement of the license.

6. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing agency in the State of California, all of the charges and allegations contained in Accusation, No. 2012-676 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict licensure.

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7. Respondent shall not apply for licensure or petition for reinstatement for two (2) years from the effective date of the Board of Registered Nursing's Decision and Order.

ACCEPTANCE

I have carefully read the above Stipulated Surrender of License and Order and have fully discussed it with my attorney, Susan Leigh Angell. I understand the stipulation and the effect it will have on my Registered Nurse License. I enter into this Stipulated Surrender of License and Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Board of Registered Nursing.

DATED: 9/20/12

JAMIE ELIZABETH COLE
Respondent

I have read and fully discussed with Respondent Jamie Elizabeth Cole the terms and conditions and other matters contained in this Stipulated Surrender of License and Order. I approve its form and content.

DATED: 9/20/12

SUSAN LEIGH ANGELL
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Surrender of License and Order is hereby respectfully submitted for consideration by the Board of Registered Nursing of the Department of Consumer Affairs.

Dated: 9/20/2012

Respectfully submitted,

KAMALA D. HARRIS
Attorney General of California
LINDA K. SCHNEIDER
Supervising Deputy Attorney General

ANTOINETTE B. CINCOTTA
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 2012-676

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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **JAMIE ELIZABETH COLE** **227 Bettyhill Avenue** **Duarte, CA 91010** **Registered Nurse License No. 604968** Respondent.	Case No. 2012-676. **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Interim Executive Officer of the Board of Registered Nursing (Board), Department of Consumer Affairs.

2. On or about August 21, 2002, the Board of Registered Nursing issued Registered Nurse License Number 604968 to Jamie Elizabeth Cole (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on October 31, 2013, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2750 of the Code provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license.

6. Section 2811(b) of the Code states:

"Each such license not renewed in accordance with this section shall expire but may within a period of eight years thereafter be reinstated upon payment of the biennial renewal fee and penalty fee required by this chapter and upon submission of such proof of the applicant's qualifications as may be required by the board, except that during such eight-year period no examination shall be required as a condition for the reinstatement of any such expired license which has lapsed solely by reason of nonpayment of the renewal fee. After the expiration of such eight-year period the board may require as a condition of reinstatement that the applicant pass such examination as it deems necessary to determine his present fitness to resume the practice of professional nursing."

STATUTORY PROVISIONS

7. Section 2761 of the Code states:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

"(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.

". . ."

8. Section 2762 of the Code states:

"In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

"(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.

". . .

"(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section."

9. Code section 4060 states:

"No person shall possess any controlled substance, except that furnished to a person upon the prescription of a physician, dentist, podiatrist, optometrist, veterinarian, or naturopathic doctor pursuant to Section 3640.7, or furnished pursuant to a drug order issued by a certified nurse-midwife pursuant to Section 2746.51, a nurse practitioner pursuant to Section 2836.1, a physician assistant pursuant to Section 3502.1, a naturopathic doctor pursuant to Section 3640.5, or a pharmacist pursuant to either subparagraph (D) of paragraph (4) of, or clause (iv) of subparagraph (A) of paragraph (5) of, subdivision (a) of Section 4052. This section shall not apply to the possession of any controlled substance by a manufacturer, wholesaler, pharmacy, pharmacist, physician, podiatrist, dentist, optometrist, veterinarian, naturopathic doctor, certified nurse-midwife, nurse practitioner, or physician assistant, when in stock in containers correctly labeled with the name and address of the supplier or producer. Nothing in this section authorizes a certified nurse-midwife, a nurse practitioner, a physician assistant, or a naturopathic doctor, to order his or her own stock of dangerous drugs and devices."

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10. Health and Safety Code section 11170 states that no person shall prescribe, administer, or furnish a controlled substance for herself.

11. Health and Safety Code section 11173, subdivision (a) states:

"No person shall obtain or attempt to obtain controlled substances, or procure or attempt to procure the administration of or prescription for controlled substances (1) by fraud, deceit, misrepresentation, or subterfuge; or (2) by the concealment of a material fact."

REGULATORY AUTHORITY

12. California Code of Regulations, title 16, section 1442 provides:

"As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

COST RECOVERY

13. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

DRUGS

14. **Ativan**, the brand name for lorazepam, is a Schedule IV controlled substance as designated by Health and Safety Code section 11057(d)(16), and is a dangerous drug pursuant to Business and Professions Code section 4022. Ativan is used in the treatment of anxiety disorders and for short-term (up to 4 months) relief of the symptoms of anxiety.

15. **Dilaudid**, a brand name for hydromorphone, is a Schedule II controlled substance as designated by Health and Safety Code Section 11055(b)(1)(J) and is a dangerous drug pursuant to Business and Professions Code section 4022. Dilaudid is a narcotic analgesic prescribed for the relief of moderate to severe pain.

16. **Morphine** is a Schedule II controlled substance as designated by Health and Safety Code section 11055(b)(1)(L) and is a dangerous drug pursuant to Business and Professions Code section 4022.

17. **Norco**, a brand name for hydrocodone with acetaminophen, is a dangerous drug pursuant to section 4022, and a Schedule II controlled substance as designated by Health and Safety Code section 11055(b)(1)(J).

FACTUAL ALLEGATIONS

18. Beginning on July 30, 2009, Respondent was employed as a registered nurse by Mercy General Hospital located in San Diego, California (Mercy). Respondent was assigned to work shifts on the Medical Surgical, Telemetry, and Progressive Units. Staff at Mercy became suspicious of Respondent's drug transaction history when Respondent was presented as an "outlier" during a random drug audit of the hospital employees' narcotic Omnicell[1] activity. The Senior Nursing Director at Mercy met with Respondent to discuss the discrepancies. During the Mercy investigation, Respondent offered no explanation for her behavior or for the narcotic discrepancies, and did not deny the allegations of drug diversion. Respondent advised the Senior Nursing Director at Mercy, "do what you gotta do, I'll get an attorney and go back into diversion." On September 1, 2010, Respondent was terminated from Mercy.

19. An internal investigation at Mercy revealed that between July 25, 2010 and August 16, 2010, Respondent made inaccurate entries in hospital and patient medical records and diverted 10.5 mg of Ativan, 6 mg of Dilaudid, 14 mg of Morphine, and 4 Norco 5/325 mg tablets from eight (8) patients as follows:

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[1] "Omnicell" is a trade name for the automatic single-unit dose medication dispensing system that records information such as patient name, physician orders, date and time medication was withdrawn, and the name of the licensed individual who withdrew and administered the medication. Each user/operator is given a user identification code to operate the control panel. Sometimes only portions of the withdrawn narcotics are given to the patient. The portions not given to the patient are referred to as "wastage." This waste must be witnessed by another authorized user and is also recorded by the Omnicell machine.

Patient A

a. On August 13, 2010, the physician ordered 1 mg Ativan IV injection as needed for anxiety. On August 15, 2010, at 12:28 hours, Respondent withdrew from the Omnicell 2 mg of Ativan for this patient. Respondent did not chart the administration of the Ativan in the patient's Medication Administration Record (MAR) or nursing notes. There is no record of wastage. Respondent failed to account for two (2) mg of Ativan.

b. On August 13, 2010, the physician ordered 1 mg Ativan IV injection as needed for anxiety. On August 15, 2010, at 16:22 hours, Respondent withdrew from the Omnicell 2 mg of Ativan for this patient. Respondent charted the administration of 1 mg of Ativan in the patient's MAR. Respondent made no notation concerning the administration of any Ativan in the nursing notes concerning this patient. There is no record of wastage. Respondent failed to account for one (1) mg of Ativan.

c. On August 13, 2010, the physician ordered 1 mg Ativan IV injection as needed for anxiety. On August 16, 2010, at 09:28 hours, Respondent withdrew from the Omnicell 2 mg of Ativan for this patient. Respondent charted the administration of 1 mg of Ativan in the patient's MAR. Respondent made no notation concerning the administration of any Ativan in the nursing notes concerning this patient. There is no record of wastage. Respondent failed to account for one (1) mg of Ativan.

d. On August 13, 2010, the physician ordered 1 mg Ativan IV injection as needed for anxiety. On August 16, 2010, at 13:35 hours, Respondent withdrew from the Omnicell 2 mg of Ativan for this patient. Respondent did not chart the administration of any of the Ativan in the patient's MAR or nursing notes. There is no record of wastage. Respondent failed to account for two (2) mg of Ativan.

e. On August 13, 2010, the physician ordered 1 mg Dilaudid IV injection every two hours as needed for severe pain (pain scale 7-10). On August 13, 2010, at 13:35 hours, Respondent withdrew from the Omnicell 2 mg of Dilaudid for this patient. Respondent did not chart the administration of any of the Dilaudid in the patient's MAR or nursing notes. There is no record of wastage. Respondent failed to account for two (2) mg of Dilaudid.

Patient B

f. On July 29, 2010, the physician ordered .5 to 1 mg Dilaudid IV injection as needed for pain. On August 4, 2010, at 14:07 hours, Respondent withdrew from the Omnicell 2 mg of Dilaudid for this patient. Respondent did not chart the administration of the Ativan in the patient's MAR or nursing notes. There is no record of wastage. Respondent failed to account for two (2) mg of Dilaudid.

Patient C

g. On August 10, 2010, the physician ordered 1 to 2 5/325mg Norco tablets as needed for pain (1 tablet for a pain scale of 3-4, and 2 tablets for pain scale of 5-6.) On August 11, 2010, at 07:07 hours, Respondent withdrew from the Omnicell 2 5/325mg Norco tablets for this patient. Respondent did not chart the administration of the Norco in the patient's MAR or nursing notes. There is no record of wastage. Respondent failed to account for two (2) 5/325 mg Norco tablets.

Patient D

h. On August 5, 2010, the physician ordered 1 mg Ativan as needed for pain every 4 hours, and .5 to 1 mg Morphine IV injection every 2 hours as needed. On August 15, 2010, at 12:49 hours, Respondent withdrew from the Omnicell 4 mg Morphine for this patient. Respondent did not chart the administration of the Morphine in the patient's MAR or nursing notes. There is no record of wastage. Respondent failed to account for four (4) mg of Morphine, and removed the Morphine 39 minutes after the last dose, and not 2 hours after the last dose per the physician's order.

i. On August 5, 2010, the physician ordered 1 mg Ativan as needed every 4 hours for pain, and .5 to 1 mg Morphine IV injection every 2 hours as needed. On August 16, 2010, at 14:20 hours, Respondent withdrew from the Omnicell 2 mg Ativan for this patient. Respondent did not chart the administration of the Ativan in the patient's MAR or nursing notes. There is no record of wastage. Respondent failed to account for two (2) mg of Ativan.

j. On August 5, 2010, the physician ordered 1 mg Ativan as needed every 4 hours for pain, and 2 to 6 mg Morphine IV injection every 2 hours as needed. On August 16, 2010, at 16:51 hours, Respondent withdrew from the Omnicell 2 mg Ativan for this patient. Respondent charted

the administration of 1 mg of Ativan in the patient's MAR, and failed to chart the administration of any Ativan in the nursing notes. There is no record of wastage. Respondent failed to account for one (1) mg of Ativan, and removed the Ativan 2 hours and 31 minutes after the last dose, and not 4 hours after the prior dose per the physician's order.

k. On August 5, 2010, the physician ordered 1 mg Ativan as needed every 4 hours for pain, and 2 to 6 mg Morphine IV injection every 2 hours as needed. On August 16, 2010, Respondent withdrew from the Omnicell 2 mg Morphine for this patient. Respondent did not chart the administration of the Morphine in the patient's MAR or nursing notes. There is no record of wastage. Respondent failed to account for two (2) mg of Morphine.

Patient F

l. On August 10, 2010, the physician ordered 1 to 2 Norco 5/325 mg tablets every 4 hours as needed for pain (1 tablet for the pain scale 3-4, 2 tablets for pain 5-6). On August 11, 2010, at 07:07 hours, Respondent withdrew from the Omnicell 2 Norco 5/325 mg tablets, and at 07:50, Respondent withdrew 2 more Norco 5/325 mg tablets. On August 11, 2010 at 07:40, Respondent charted the administration of 2 Norco 5/325 mg in the patient's MAR. Respondent did not chart the administration of the Norco in the patient's nursing notes. There is no record of wastage. Respondent failed to account for two (2) Norco 5/325 mg tablets.

Patient G

m. On August 10, 2010, the physician ordered 2-6 mg Morphine IV every 2 hours as needed for pain. On August 10, 2010, at 09:35 hours, Respondent withdrew from the Omnicell 4 mg of Morphine. On August 10, 2010, Respondent charted the administration of 2 mg Morphine in the patient's MAR. Respondent did not chart the administration of the Morphine in the patient's nursing notes. There is no record of wastage. Respondent failed to account for two (2) mg of Morphine.

n. On August 10, 2010, the physician ordered 2-6 mg Morphine IV every 2 hours as needed for pain. On August 10, 2010, at 12:39 hours, Respondent withdrew from the Omnicell 4 mg of Morphine. On August 10, 2010, Respondent did not chart the administration of any of the

Morphine in the patient's MAR or nursing notes. There is no record of wastage. Respondent failed to account for four (4) mg of Morphine.

Patient H

o. On July 25, 2010, the physician ordered 1 mg Dilaudid every 2 hours as needed for pain. On August 4, 2010, at 13:27 hours, Respondent withdrew from the Omnicell 2 mg of Dilaudid. On August 4, 2010, Respondent charted the administration of 1 mg Dilaudid in the patient's MAR. Respondent did not chart the administration of the Dilaudid in the patient's nursing notes. There is no record of wastage. Respondent failed to account for one (1) mg of Dilaudid.

p. On July 25, 2010, the physician ordered 1 mg Dilaudid every 2 hours as needed for pain. On August 4, 2010, at 15:29 hours, Respondent withdrew from the Omnicell 2 mg of Dilaudid. On August 4, 2010, Respondent charted the administration of 1 mg Dilaudid in the patient's MAR. Respondent did not chart the administration of the Dilaudid in the patient's nursing notes. There is no record of wastage. Respondent failed to account for one (1) mg of Dilaudid.

Patient I

q. On August 13, 2010, the physician ordered .5 to 1 mg Ativan IV every 4 hours as needed for anxiety, and 2 to 6 mg Morphine IV every 2 hours as needed for pain. On August 13, 2010, at 12:36 hours, Respondent withdrew from the Omnicell 2 mg of Ativan. On August 13, 2010, Respondent charted the administration of .5 mg Ativan in the patient's MAR. Respondent did not chart the administration of the Ativan in the patient's nursing notes. There is no record of wastage. Respondent failed to account for one and one-half (1.5) mg of Ativan.

r. On August 13, 2010, the physician ordered .5 to 1 mg Ativan IV every 4 hours as needed for anxiety, and 2 to 6 mg Morphine IV every 2 hours as needed for pain. On August 13, 2010, Respondent withdrew from the Omnicell 2 mg of Morphine. Respondent did not chart the administration of the Morphine in the patient's MAR or nursing notes. There is no record of wastage. Respondent failed to account for two (2) mg of Morphine.

20. On or about September 20, 2010, nineteen (19) days after she was terminated by Mercy for drug diversion, Respondent was hired as a registered nurse by Fountain Valley Regional Hospital (FVRH).

21. On December 6, 2010, Respondent called her physician to advise that Norco was not helping with her pain, and that she wanted to try a different medication. Her physician prescribed an additional pain medication, and directed Respondent to decrease her Norco intake to four tablets a day (QID).

22. In January 2011, the administration at FVRH counseled Respondent for higher than average administration of narcotic medications to her assigned patients. Although Respondent was not outside the doctors' orders, she was administering full dosages of the as needed medications which were not consistent with the administration rates of her peers medicating the same patients on alternating shifts.

23. On January 17, 2011, Respondent called her physician requesting a refill for Norco one week early. Respondent advised her physician that she had filled the prescription for the alternative pain medication because she did not want to start another narcotic. Respondent also admitted to taking 6 tablets of Norco a day. Respondent's physician authorized a one-time-only early refill of the Norco, and again directed Respondent to take the Norco only as prescribed.

24. On March 17, 2011, Respondent was also interviewed by FVRH administration concerning her drug administration. Respondent also provided a urine sample at the request of the FVRH administration. The urine test was positive for the presence of Marijuana. Respondent was escorted to that meeting from her assigned floor by an employee health nurse. On the day of the meeting, another employee found a packet containing Norco near a time card reader where Respondent had swiped her employee badge before leaving the unit. A 24-hour surveillance video recorded Respondent removing the packet of Norco from her pocket, and placing it onto a counter near the card reader. The Norco package was identified by lot number, and was confirmed to have come from the FVRH supply.

25. On March 29, 2011, the FVRH Director, a representative of FVRH Employee Health, and a member of FVRH Human Resources interviewed Respondent. During that meeting, before Respondent was advised that her urine test was positive for Marijuana, Respondent admitted that she had been under significant stress, and she admitted to having smoked Marijuana the week before. Respondent initially denied stealing the Norco from FVRH. After Respondent was

informed of the 24-hour surveillance video, she admitted to having taken the Norco because she "felt desperate" after running out of her own medication.

26. On March 31, 2011, FVRH received an e-mail from Respondent in which she stated she did not steal the Norco, and felt pressured over the previous meeting. Respondent said she was not going to self-report to the Board because she was going to move to Florida to continue working as a nurse. Respondent asked that FVRH accept her resignation in lieu of termination for her drug diversion.

FIRST CAUSE FOR DISCIPLINE

(False Entries in Hospital/Patient Records)

27. Respondent is subject to disciplinary action under section 2761(a), on the grounds of unprofessional conduct, as defined in Code section 2762(e), in that between or about July 25, 2010 to August 16, 2010, while on duty as a registered nurse at Mercy General Hospital, San Diego, California, Respondent falsified, or made grossly incorrect, grossly inconsistent, or unintelligible entries in hospital, patient, or other records pertaining to the controlled substances, as is detailed in paragraphs 18 through 19, above, which are incorporated herein by reference.

SECOND CAUSE FOR DISCIPLINE

(Obtain, Possess and Administered Controlled Substances)

28. Respondent is subject to disciplinary action pursuant to Code section 2761(a), on the grounds of unprofessional conduct, as defined by Code section 2762(a), and in violation of Code section 4060, and Health and Safety Code sections 11170 and 11173, subdivision (a), in that while on duty as a registered nurse at Mercy and FVRH, Respondent obtained, possessed, and/or administered to herself the controlled substances, as set forth in paragraphs 18 through 26, above, which are incorporated herein by reference.

THIRD CAUSE FOR DISCIPLINE

(Gross Negligence)

29. Respondent is subject to disciplinary action pursuant to Code section 2761(a), subdivision (1), on the grounds of unprofessional conduct, as defined by California Code of Regulations, title 16, section 1442, in that while on duty as a registered nurse at Mercy and

FVRH, Respondent repeatedly engaged in the failure to provide nursing care as required or engaged in the failure to provide care or to exercise ordinary precaution in a single situation which she knew, or should have known, could have jeopardized the client's health or life as set forth in paragraphs 18 through 26, above, which are incorporated herein by reference.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 604968 issued to Jamie Elizabeth Cole;

2. Ordering Jamie Elizabeth Cole to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: May 1, 2012

LOUISE R. BAILEY, M.ED., RN
Interim Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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